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	17E613	A. BUILDING _____ B. WING _____	01/22/2015

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This Requirement is not met as evidenced by:
The facility had a census of 32 residents. The sample included 13 residents. Based on observation, interview and record review the facility failed to notify the appropriate state agency of an unwitnessed fall with a nasal fracture for 1 of the 3 sampled residents residents reviewed for accidents/falls. (#7)

Findings included:

- Resident #7's medical record revealed diagnoses of dementia (a loss of brain function that occurs with certain diseases and it affects memory, thinking, language, judgment, and behavior), depression (a state of feeling sad, a mood disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of rejection and hopelessness), Hypertension (high blood pressure, which the blood pressure is the force of blood pushing against the walls of the arteries as it flows through them), and nutritional deficiency, (disease caused by a lack or inadequate supply of essential nutrients such as vitamins and minerals, in the diet resulting in malnutrition or disease).

The admission (MDS) Minimum Data Set assessment, dated 12/08/2014, indicated the resident had severely impaired cognition, independent with (ADLs) Activities of Daily Living for transfers, walking in his/her room, and limited one person assistance with toilet use. The MDS indicated the resident had one fall prior to his/her

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admission to the facility with no injury, and his/her balance was steady all of the time during transition/walking. The MDS indicated he/she ambulated with the assistance of a walker.

The 8/13/2014 fall (CAAs) Care Area Assessment summary indicated the resident had a high risk for falls and a history of falls. The CAAs indicated the resident required minimal assistance with all ADLs and needed cueing to go to meals and activities. The MDS indicated the resident was incontinent of urine at times and required assistance with toileting. Continued review revealed the resident had severe cognitive impairment.

The 8/20/2014 care plan indicated the resident required supervision with personal hygiene, and bathing, had the potential for falls, required supervision, and walked independently in his/her room and halls. The 11/23/2014 updated care plan revealed the resident had periods of hallucinations, and confusion due to short and long term memory loss. The 12/08/2014 update indicated the staff encouraged the resident to use his/her call light for assistance and perform 30 minute visual checks. The 12/31/2014 updated care plan indicated the resident was legally blind in his/her left eye but did have adequate vision in his/her right eye.

The 9/08/2014 fall risk assessment score was 8, on a 1-10 scale, with a score of 10 or higher representing a high fall risk.

The 12/08/2014 at 2:30 AM, nurse's notes revealed the resident had an unwitnessed fall and staff observed the resident on the bathroom floor during rounds. The staff called the nurse to the room, who noted blood on the floor around the

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resident and a small laceration to his/her forehead 2 inches x 2 inches with a hematoma (localized swelling filled with blood within the tissue) with blood coming from his/her nose. The resident stated he/she fell but was unable to explain how it happened. The nurse contacted the physician who ordered cold compresses to head/nose, continue neuros, and transport the resident to the hospital in the morning for x-rays.

The 12/08/2014 at 8:45 AM, nurse's notes revealed the staff notified the primary care physician of the resident's fall and orders clarified for x-rays. He/she stated to keep an eye on the resident, notify him/her of any problems and do not obtain x-rays. At 3:31 PM the facility received a new order to obtain a (CT) Computerized tomography of the resident's nose and sinuses.

The 12/08/2014 post fall assessment revealed the staff found the resident on the floor and assessed him/her for injuries. The investigation revealed the resident stated he/she had a fall in the bathroom and was unable to tell the staff what made him/her fall. Staff notified the physician regarding the fall.

Review of the Neurological Record, vital signs, and neuros were obtained from 12/08/2014 until 12/11/2014.

The 12/09/2014 at 2:21 PM, nurse's notes revealed the resident continued to have a dark purple bruise around his/her eyes. The resident denied any trouble breathing.

The 12/10/2014 at 2:30 PM, nurse's notes indicated the CT scan results revealed the resident had a nasal fracture.

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The 12/10/2014 CT scan results of the resident's facial bones revealed a depressed fracture involving the anterior nasal bone which is displaced towards the left.

On 1/14/2015 at 7:45 AM, observation revealed the resident seated in a recliner in his/her room, with feet elevated. Nurse Aide J assisted the resident with dressing and noted the resident had gripper socks on his/her feet. The resident stood with 1 staff and a gaitbelt and took a few steps to sit in his/her wheelchair.

On 1/14/2015 at 7:50 AM, Nurse Aide J verified the resident would get up on his/her own without calling for staff assistance. Nurse Aide I stated the resident required oxygen for shortness of breath, can go without it but should have it on, and he/she resident ambulates with a walker.

On 1/15/2015 at 11:45 AM, Administrative Nurse C verified the resident had an unwitnessed fall with injury, on 12/08/2014, in his/her bathroom, and the resident indicated he/she fell and did not know what happened. Administrative Nurse C verified the resident was cognitively impaired and had a BIMS score of #07.

On 1/15/2015 at 11:45 AM, Administrative Staff Q verified the resident had a fall on 12/08/2014 with injury, but thought the information he/she received indicated the resident was alert and oriented and was not aware he/she was cognitively impaired and unable to tell the staff how the fall/injury happened.

On 1/15/2015 at 11:45 AM, Administrative Nurse C verified the resident had an unwitnessed fall in

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F 225	Continued From page 5 his/her bathroom that resulted in a nasal fracture. Administrative Nurse C verified he/she did not cal the unwitnessed fall of the cognitively impaired resident into the State agency. The 3/2012 facility Policy for Prevention of Abuse, Neglect and Exploitation stated the facility would work to assure that all residents will be free of physical, emotional and sexual abuse, neglectful treatment and misappropriation of funds and resources. The purpose would be to establish guidelines for determine abuse and neglect of patients/residents and to provide patient/resident families and staff information on whom and to whom to report concerns incidents and grievances without fear or retribution. The facility failed to immediately report an unwitnessed fall with a nasal fracture of Resident #7, to the State agency.	F 225		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to ensure adequate pain management during wound care for 1 of 1	F 309		

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F 309	Continued From page 6 residents reviewed for pain management. (#9) Findings included: - Resident #9's physician's order, dated 1/07/2015, revealed diagnoses of Cerebral Vascular Accident (the sudden death of some brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), Hypertension (high blood pressure, which the blood pressure is the force of blood pushing against the walls of the arteries as it flows through them), Congestive Heart Failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissue), dermatitis/eczema (a condition that makes your skin red and itchy), pain, edema (condition characterized by an excess of watery fluid collecting in the cavities or tissue of the body), confusion, tinea crusis (fungal infection involving the groin), atrial fibrillation (an irregular and often rapid heart rate that causes poor blood flow to the body), psoriasis (a skin disease marked by red, itchy, scaly patches), Bullous Pemphigoid (a rare skin condition that causes large, fluid-filled blisters on areas of skin that often flex, such as the lower abdomen, upper thighs, or armpits), and Onychomycosis (fungal infection of the nails). The quarterly (MDS) Minimum Data Set assessment, dated 12/03/2014, indicated the resident had severely impaired cognition and required limited assistance with transfers, dressing, toilet use and personal hygiene The MDS indicated the resident had open skin lesions other than ulcers, rashes, cuts, that were moisture associated skin damage. The MDS indicated the resident had a pressure reducing device for bed/chair, application of ointments	F 309		

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other than to feet, had no pain, and did not receive any scheduled or as needed pain medication.

The 12/10/2014 care plan instructed the staff to provide assistance to the resident with transfers and toileting. The care plan indicated the resident was at risk for impaired skin integrity due to urine incontinence, scratching of the skin and a diagnoses of bullous pemphigoid. The care plan indicated the staff would assess the resident's skin problems daily, chart weekly, provide tubigrips (tubular elastic bandage to provide support for sprains, strains and weak joints) to his/her arms, and wash his/her clothes in dreft detergent. The care plan instructed the resident would be on contact isolation due to the infection, and staff to encourage the resident not to pick or scratch.

The 12/03/2014 pain assessment indicated the resident voiced no complaints of pain or discomfort.

Review of the medical record revealed the 01/07/2015 physician's order directed the staff to administer Xanax (antianxiety medication) 0.25 mg 1-2 tablets every 4-6 hours as needed for anxiety.

Review of the January 2015 (MAR) Medication Administration Record revealed the following assessment of the resident's pain using a 1-10 scale. resident received Norco (narcotic, pain medication) 5/325 (mg) milligrams 1 every 4-6 hours as needed for pain on 1/11, 1/12, and 1/14/2015. The MAR revealed the resident

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F 309	Continued From page 8 received Xanax 0.25 mg 1 or two tablets as needed on 1/07, 1/08, 1/09, and 1/10/2015. The MAR revealed the resident received Tylenol 325 mg, two tablets every 4-6 hours as needed for pain that was rated 1-3, on 1/01- twice, 1/02 -twice, 1/03, 1/04, 1/05, 1/06 three times, 1/07, 1/08, 1/09, and 1/10/2015. The 12/22/2014 nursing progress notes revealed the resident complained of increased blisters on his/her hands, arms, abdomen and legs. The resident has a hive-type rash across his/her abdomen with a diagnosis of bullous pemphigoid. The resident had been treated with Prednisone and Doxycycline and cultures from blisters in October revealed MRSA. (Methacillin Resistant Staph Aureus) Review of the 1/09/2015 Physical Therapy outpatient evaluation revealed the resident had multiple open wounds secondary to a diagnosis of bullous pemphigoid to his/her trunk, left lower extremity and foot with MRSA infection. The Physical Therapy evaluation states the resident had been on contact isolation since 10/08/2014. The resident had complaints of the blisters being itchy since the onset with the resident scratching and picking at the scabs indicating they were very itchy and the cultures were positive for MRSA. The resident received his/ her meals in his/ her room with staff assistance to eat, as needed. The resident does have a tendency to sleep most of the time, however dressing changes have been painful for him/her to endure. The resident was prescribed Xanax 1-2 tablets by mouth every 4-6 hours for pain and anxiety. The physical therapist assessment of the wounds revealed the resident very symptomatic, despite use of a topical	F 309		

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lidocaine, Xanax, as well as his/her usual pain medication, prior to debridment. The resident had significant difficulty tolerating sitting up in the recliner to allow the trunk wounds to be treated, at times requiring nearly total assistance of the restorative aide to help him/her maintain balance. The resident had a brief episode of decreased responsiveness, becoming more limp, and was allowed to rest in the chair for approximately 5 minutes before trying to complete wound care. The evaluation recommended physical therapy 3 times a week and the staff to complete dressing changes one time on the weekend, or as needed if soiled.

On 1/14/2015 at 9:45 AM, observation revealed Nurse Aide E and Nurse Aide J assisted the resident from his/her bed to the wheelchair using a total body lift. The resident grimaced and said "ouch" with the transfer and staff reassured him/her they were about finished with the transfer. Observation revealed the sling lift came across the wounds on his/her left thigh as the staff transferred the resident to the wheelchair. Observation of the resident's right foot and upper left thigh and right mid to low back revealed the areas covered with kerlix (a white, gauze dressing).

On 1/15/2015 at 10:10 AM, observation revealed Therapy Staff E and Restorative Aide J removed a dressing from the resident's right medial 1st toe and forefoot wound, revealing reddish bloody drainage. Therapy Staff E cleansed the area with normal saline and applied 4% topical lidocaine and applied Bactroban, Adaptic, and Cavalon barrier wipe. The resident cried out stating "ouch", the staff then asked

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him/her if he/she hurt and he/she would just grimace. Therapy Staff E removed dressings from the resident's posterior shoulders, upper and lower back area and all the wounds were irrigated with sodium chloride and patted dry with sodium chloride sterile towel to remove the exudate (fluid leaking from a wound). Therapy Staff E applied a 4% topical lidocaine to the wounds. The resident complained of pain with the dressing changes and displayed frequent facial griminacing.

On 1/13/2015 at 4:10 PM, Administrative Nurse C verified the resident had dressing changes to his/her wounds but did not know he/she had pain with the procedure. Administrative Nurse C verified the resident should be administered pain medication prior to the procedure if he/she was experiencing pain.

On 1/14/2015 at 4:10 PM, Restorative Aide E verified the resident's dressing changes are painful for the residents and indicated he/she received pain medication with the procedure. Restorative Aide E verified the wounds were getting worse, more painful and spreading.

On 1/15/2015 at 1:10 PM, Physical Therapist K verified the therapy staff had been doing the resident's dressing changes three times a week, and once on the weekend by the restorative aide for the last week. Physical Therapist K indicated the dressing changes take approximately 1 and 1/2 hours to complete, and the resident does have pain even though the resident had received Norco (narcotic, pain medication) prior to the procedure.

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F 309	Continued From page 11 On 1/21/2015 at 2:55 PM, Physician T indicated he/she had ordered Morphine every 2 hours and as needed with dressing changes on 1/15/2015 and stated the resident's pain was now under control. The facility 6/15/2011 Pain Management policy is to provide the resident with adequate pain relief and management in order to promote optimal comfort, participate in activities, and facilitate resident completion of activities of daily living within existing limits. Adequate pain management is a mutually determined goal between the resident and/or family and health care professional. The facility is committed to appropriate and adequate pain management for all residents. The policy for pain management will be a part of the resident's initial and ongoing assessment. Residents who are experiencing pain have the right to have their pain relieved to the greatest extent possible. The nurses goal is to reduce pain at least to a level specified by the recipient of care, while recognizing that all persons have the right to refuse treatment. The facility failed to provide adequate and effective pain management for Resident #9, who expressed verbal and non verbal signs of pain during cares and dressing changes.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 12 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents of which 3 were reviewed for urinary catheter. Based on observation, record review, and interview, the facility failed to provide appropriate catheter care to prevent infections and to ensure a resident is not catheterized unless a clinical condition demonstrates that catheterization was necessary for 2 of 3 residents reviewed for urinary catheter use. (#24, #1) Findings included: - Resident #24's quarterly (MDS) Minimum Data Set assessment, dated 10/17/14, indicated the resident had short and long term memory problems, moderately impaired cognition, and total dependence on 2 staff with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. The MDS further indicated the resident had an indwelling urinary catheter and received insulin, antidepressant and diuretic medications. The 10/29/14 care plan directed the staff to provide catheter care every shift and as needed. The 1/7/15 physician's orders indicated the resident had an indwelling urinary catheter (initiated on 5/7/14) for the diagnosis of urinary retention (lack of ability to urinate and empty the bladder) and directed the staff to change the resident's foley catheter monthly.	F 315		

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Review of the medical record indicated the resident had a (UTI) Urinary Tract infection on 12/11/14, 9/24/14 and 8/7/14.

On 1/13/15 at 4:38 PM, observation revealed Nurse Aide A and Nurse Aide B entered Resident #24's room to assist the resident to get up for supper. Nurse Aide A and B went into the bathroom, washed their hands, and applied gloves. Nurse Aide B obtained the graduated cylinder from the bathroom, unhooked the drainage spout from the side of the catheter bag and emptied the yellowish/orange urine into the cylinder. Nurse Aide B reattached the drainage spout to the side of the catheter bag and did not wipe the drainage spout with an alcohol wipe. Nurse Aide B held the catheter bag below the level of the bladder while transferring the resident from the bed to the wheelchair. After completing incontinent cares and toileting, the aides assisted the resident into a wheelchair and attached his/her catheter bag under the wheelchair seat and the bag touched the floor. The aides pushed the resident into the dining room with the catheter bag dragging on the floor.

On 1/14/15 at 7:46 AM and 1/15/15 at 7:47 AM, observation revealed Resident #24, seated at the dining room table, in a wheelchair, with the catheter bag hooked under the wheelchair seat and touching the floor.

On 1/14/15 at 9:47 AM, observation revealed Resident #24 seated in his/her recliner with his/her feet up and the catheter tubing with dark yellow urine, draped over the left arm of the recliner, above the level of the bladder.

On 1/14/15 at 2:39 PM, Nurse Aide B stated

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he/she did not wipe the spout on the catheter bag when he/she emptied it into the graduated cylinder.

On 1/15/15 at 8:50 AM, Administrative Nurse C stated the staff should wipe off the catheter port after emptying the urine in the graduated cylinder and should not drape the catheter tubing over the arm of the recliner.

On 1/15/15 at 11:00 AM, Nurse D stated the resident's catheter bag should not touch the floor.

The facility's 4/6/14 Urinary Catheter Care Policy directed the staff that the catheter and tubing must remain patent, with the drainage bag kept below the level of the bladder, to maintain unobstructed urine flow and prevent pooling and backflow of urine into the bladder.

The facility failed to provide appropriate catheter care to prevent infections for Resident #24, who had a history of urinary tract infections.

- Resident #1's annual (MDS) Minimum Data Set, dated 10/12/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 which indicated the resident had intact cognition.Further review of the MDS revealed the resident needed extensive assistance with transfers and toileting and was always incontinent of urine.

The urinary incontinence (CAA) Care Area Assessment Summary, dated 10/19/14, revealed the resident needed staff assistance with going to the bathroom and assistance with incontinent care.

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The 10/12/14 care plan directed the staff to make sure the resident wears incontinent briefs.

Review of the medical record revealed the resident had been admitted to the hospital on 1/2/15 with diagnosis of respiratory distress (shortness of breath and difficulty with breathing) and had been discharged and returned to the facility on 1/12/15. Further review of the medical record revealed the resident returned to the facility with a foley catheter (a tube inserted into the bladder to drain urine into a collection bag) and the physician orders on the transfer sheet had no diagnosis for the urinary catheter.

The 1/12/15 updated care plan, directed the staff to perform foley catheter care every shift. Review of the medical record revealed no diagnosis for the resident's indwelling urinary catheter.

On 1/12/15 at 5:15 PM, observation revealed the staff pushing the resident into the dining room in his/her wheelchair. Further observation revealed an audible swishing noise coming from the resident's wheelchair. Further observation revealed the urinary catheter bag attached under his/her wheelchair with the bottom of the bag dragging against the tile floor.

On 1/13/15 at 11:50 AM, observation revealed the staff pushing the resident in his/her wheelchair into the dining room and the catheter bag dragging against the tile floor.

On 1/14/15 at 1:00 PM, observation revealed staffing pushing the resident in his/her wheelchair into his/her room. Further observation revealed Nurse Aide E applying clean gloves, then placed a graduated cylinder (a clear plastic container

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This Requirement is not met as evidenced by:
The facility had a census of 32 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to provide an environment free from accident hazards for 11 residents identified by the facility as cognitively impaired and independently mobile.

Findings included:

- On 1/12/15 at 3:18 PM, observation during the initial tour revealed an unlocked cabinet in the dining room, with a container of PDI Super Sani Cloth germicidal disposable wipes approximately 1/2 full with a warning label that directed the staff to "Keep Out of Reach of Children", "Causes irreversible eye damage" and "Avoid contact with skin".

On 1/14/15 at 10:30 AM, observation revealed a staff member placed a container of PDI Super Sani Cloth germicidal wipes on top of a plastic bin outside of Resident #8's room for approximately 10 minutes. Observation further revealed 3 residents and 2 staff walked past the plastic bin where the container of germicidal wipes remained unattended and within reach.

On 1/12/15 at 3:18 PM, Nurse I verified the PDI Super Sani Cloth disposable wipes are to be locked in the janitors closet at all times.

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F 323	Continued From page 18 On 1/14/15 at 10:42 AM, Administrative Nurse C verified the staff should not leave a container of PDI Super Sani Cloth disposable wipes unattended. The facility's 4/3/14 Exposure Control Plan directed the staff to store cleaning and disinfectant products in a secure manner. During use, the products must be either under the direct visual supervision of the user or in a locked cart or cabinet. Storage of facility chemical inventory is restricted to a locked room. The facility failed to provide an environment as free of accident hazards as possible for 11 cognitively impaired, independently mobile residents, who reside in the facility.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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F 329	Continued From page 19 drugs. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to follow physician's orders for pulse monitoring and failed to adequately monitor bowel management for 1 of 5 residents reviewed for medications. (#31) Findings included: - Resident #31's quarterly (MDS) Minimum Data Set assessment, dated 12/9/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 9, which indicated moderately impaired cognition, and required minimal assistance of 1 staff with bed mobility, transfer, dressing and toilet use. The MDS indicated the resident's balance was not steady, only able to stabilize with staff assistance, had 1 fall and received insulin, antidepressant, anticoagulant, antibiotic and diuretic medications. The 12/17/14 care plan directed the staff to administer medications, as ordered by the physician, and to monitor the resident's vital signs as needed. The 9/3/14 physician's progress note directed the staff to obtain the resident's blood pressure and pulse 3 times a day for a week and fax the results to the physician. Review of the resident's medical record revealed no documentation of this	F 329		

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information.

The 12/3/14 physician's orders (initiated on 3/4/14) directed the staff to:
-Administer Xarelto(a medication to help prevent blood clots), 10 (mg) milligrams, by mouth daily to the resident at bedtime.
-Obtain the resident's pulse twice a day and report any pulse over 85.

The order further directed the staff to obtain the resident's pulse and if the pulse <45 or >110 to recheck in 30 minutes and if still abnormal, to call the physician.

The facility's monthly blood pressure and pulse flow sheets directed the staff to recheck the resident's pulse in 30 minutes if <45 or >85 and if still abnormal, to telephone the physician.

Review of the monthly blood pressure and pulse flow sheets revealed the resident had a pulse greater than 85 and no documentation of follow up or physician notification:
June 2014, pulse greater than 85 obtained 29 times.
July 2014, pulse greater than 85 obtained 35 times.
August 2014, pulse greater than 85 obtained 18 times.
September 2014, pulse greater than 85 obtained 25 times.
September 2014, pulse greater than 85 obtained 25 times.
November 2014, pulse greater than 85 obtained 16 times.
December 2014, pulse greater than 85 obtained 25 times.

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F 329	Continued From page 21 On 1/14/15 at 9:52 AM, Nurse N stated the medication aides obtain the resident's pulse twice a day and should tell the nurse if the pulse is >85. Nurse N verified the pulse obtained on this date was 103 and he/she was not notified of this pulse. On 1/14/15 at 1:05 PM, Administrative Staff O verified the facility had no documentation of the 9/3/14 physician ordered blood pressures and pulses and the physician's office had not received a fax from the facility regarding the 9/3/14 physician ordered blood pressures and pulses. On 1/14/15 at 1:44 PM, Administrative Nurse C stated the staff should have clarified, with the physician, the 3/4/14 orders which instructed the staff to obtain the resident's blood pressure and pulse twice daily and report any pulse >85 and the 3/4/14 Xarelto order which instructed the staff if the resident's pulse was <45 or >110 to recheck in 30 minutes and if still abnormal to call the physician. Administrative Nurse C stated the staff did not follow the 9/3/14 physician's orders which directed the staff to obtain the resident's blood pressure and pulse 3 times daily for a week and then fax the report to the physician. On 1/14/15 at 1:55 PM, Medication Aide L stated he/she did not recheck the resident's pulse when it was greater than 85 and verified at the bottom of the blood pressure and pulse flowsheet were directions for the staff to recheck any pulse >85 in 30 minutes and if still high to call the physician. Review of the facility's standing orders indicated if a resident had not had a bowel movement for 1 day, the staff were to administer prune or apple juice in the morning and evening, 2 days, administer (MOM) Milk of Magnesia (a laxative), 30 (ml) milliliters, orally in the morning, 3 days,	F 329		

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administer a fleets enema in the morning, and if the constipation was not relieved by the fleets enema, the staff were to notify the physician.

Review of the 12/3/14 physician's orders directed the staff to administer Colace (a laxative) 100 mg, 1 tablet orally, twice a day, and MOM, 30 ml orally as needed.

Review of the medical record revealed the resident had no bowel movement 1/6/15 through 1/12/15 (7 consecutive days) and 11/22/14 through 11/27/14 (6 consecutive days).

Review of the January 2015 and November 2014 (MARs) Medication Administration Records revealed no documentation the staff administered any bowel management interventions for the timeframes listed above as directed by the physician's standing orders.

Review of the nurse's notes for 1/6/15 to 1/11/15 and 11/22/14 to 11/27/14, revealed no bowel assessments and no indication the staff provided any bowel elimination interventions to the resident.

On 1/14/15 at 8:58 AM, observation revealed the staff assisting the resident from his/her recliner to the wheelchair.

On 1/15/15 at 9:45 AM, Nurse D stated the aides monitor the resident's bowel movements and report to the nurses if a resident has not had a bowel movement in 3 days.

On 1/15/15 at 9:47 AM, Nurse Aide M stated the staff assist the resident to the bathroom at all times and document the bowel movements on a flow sheet. Nurse Aide M stated if a resident had

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F 329	Continued From page 23 not had a bowel movement in 3 days, the staff would tell the nurse and he/she would provide interventions to the resident. On 1/15/15 at 10:18 AM, Administrative Nurse C stated the aides monitor the bowel movements for all of the residents and the aides should let the nurses know if the resident has not had a bowel movement in 3 days. Administrative Nurse C stated he/she would expect the nurses to do a bowel assessment on the residents who have not had a bowel movement in 3 days and document the assessment in the nurse's notes. Administrative Nurse C verified the staff failed to implement the standing orders and perform a bowel assessment for the timeframes listed above. The facility failed to follow the physician's orders for pulse monitoring and adequately monitor bowel elimination program and provide timely interventions as ordered by the physician for Resident #31.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents. Based on	F 371		

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observation, record review and interview, the facility failed to prepare and serve food under sanitary conditions and maintain food at adequate temperatures for the 32 residents who received their meals from the facility kitchen.

Findings included:

- On 1/12/15 at 2:41 PM, during the initial kitchen tour, observation revealed several dietary staff with approximately 1-2 inches of hair hanging outside of the hairnets during the evening meal preparation.

On 1/13/15 at 11:43 AM, observation revealed several dietary staff assisted with the serving of the lunch meal, in the kitchen, with approximately 1-2 inches of hair hanging outside of the hairnets.

On 1/14/15 at 11:02 AM, during the full tour of the kitchen, observation revealed 1 male dietary staff preparing lunch and 1 male dietary staff washing dishes with approximate 1-2 inches of hair hanging outside of the hairnets around the ears and the back of the head and 2 female dietary staff assisting with lunch preparation with approximate 1 inch hairs hanging outside of the hairnets at the sides and back of the head.

On 1/15/15 at 2:22 PM, review of the December temperature log on the snack refrigerator revealed temperatures ranging from 42 - 45 degrees on all days of December and at the top of the temperature log was a statement that indicated the temperature should be 41 degrees or below. The thermostat on the outside of the refrigerator read 43 degrees and inside the refrigerator were evening snacks, which included puddings, juices, cheese and supplements, for the residents. Observation revealed no

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F 371	Continued From page 25 thermometer inside of the refrigerator. On 1/14/15 at 4:32 PM, Dietary Staff R verified the staff's hair was not completely contained in the hairnets on 3 days of the survey. On 1/15/15 at 8:34 AM, Dietary Staff S verified the staff should have all of their hair contained in hairnets at all times. Dietary Staff S verified the temperatures on the snack refrigerator log were not below 41 degrees and the dietary staff had not told him/her of the out of range temperatures. The facility's 6/3/14 Sanitary Food Service policy stated dietary staff should be neat and clean, with appropriate hair covering. The facility failed to prepare and serve food under sanitary conditions and maintain food at adequate temperatures for the 32 residents who reside in the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents of which 5 were reviewed for unnecessary medications. Based on	F 428		

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observation, record review and interview, the facility's pharmacist consultant failed to identify and address with the director of nursing, or the physician, the failure to follow physician's orders for pulse monitoring and failed to adequately monitor bowel management for 1 of 5 residents reviewed for medications. (#31)

Findings included:

- Resident #31's quarterly (MDS) Minimum Data Set assessment, dated 12/9/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 9, which indicated moderately impaired cognition, and required minimal assistance of 1 staff with bed mobility, transfer, dressing and toilet use. The MDS indicated the resident's balance was not steady, only able to stabilize with staff assistance, had 1 fall and received insulin, antidepressant, anticoagulant, antibiotic and diuretic medications.

The 12/17/14 care plan directed the staff to administer medications, as ordered by the physician, and to monitor the resident's vital signs as needed.

The 9/3/14 physician's progress note directed the staff to obtain the resident's blood pressure and pulse 3 times a day for a week and fax the results to the physician. Review of the resident's medical record revealed no documentation of this information.

The 12/3/14 physician's orders (initiated on 3/4/14) directed the staff to:

-Administer Xarelto(a medication to help prevent blood clots), 10 (mg) milligrams, by mouth daily to the resident at bedtime.

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F 428	Continued From page 27 -Obtain the resident's pulse twice a day and report any pulse over 85. The order further directed the staff to obtain the resident's pulse and if the pulse <45 or >110 to recheck in 30 minutes and if still abnormal, to call the physician. The facility's monthly blood pressure and pulse flow sheets directed the staff to recheck the resident's pulse in 30 minutes if <45 or >85 and if still abnormal, to telephone the physician. Review of the monthly blood pressure and pulse flow sheets revealed the resident had a pulse greater than 85 and no documentation of follow up or physician notification: June 2014, pulse greater than 85 obtained 29 times. July 2014, pulse greater than 85 obtained 35 times. August 2014, pulse greater than 85 obtained 18 times. September 2014, pulse greater than 85 obtained 25 times. September 2014, pulse greater than 85 obtained 25 times. November 2014, pulse greater than 85 obtained 16 times. December 2014, pulse greater than 85 obtained 25 times. Review of the Pharmacist Consultant records for the above listed timeframes revealed the pharmacist had not addressed the facility's failure to follow blood pressure parameters and the failure to follow the 9/3/14 physician's orders. On 1/14/15 at 1:44 PM, Administrative Nurse C	F 428		

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stated the consultant pharmacist had not addressed the failure to follow blood pressure parameters for Resident #31.

Review of the facility's standing orders indicated if a resident had not had a bowel movement for 1 day, the staff would administer prune or apple juice in the morning and evening, 2 days, administer (MOM) Milk of Magnesia (a laxative), 30 (ml) milliliters, orally in the morning, 3 days, administer a fleets enema in the morning, and if the constipation was not relieved by the fleets enema, the staff were to notify the physician.

Review of the 12/3/14 physician's orders directed the staff to administer Colace (a laxative) 100 mg, 1 tablet orally, twice a day, and MOM, 30 ml orally as needed.

Review of the medical record revealed the resident had no bowel movement 1/6/15 through 1/12/15 (7 consecutive days) and 11/22/14 through 11/27/14 (6 consecutive days).

Review of the January 2015 and November 2014 (MARs) Medication Administration Records revealed no documentation the staff administered any bowel management interventions for the timeframes listed above as directed by the physician's standing orders.

Review of the nurse's notes for 1/6/15 to 1/11/15 and 11/22/14 to 11/27/14, revealed no bowel assessments and no indication the staff provided any bowel elimination interventions to the resident.

Review of the Pharmacist Consultant record for November 2014, revealed the pharmacist had not addressed the lack of bowel monitoring for the

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F 428	Continued From page 29 time period 11/22 to 11/27. On 1/14/15 at 8:58 AM, observation revealed the staff assisting the resident from his/her recliner to the wheelchair. On 1/15/15 at 10:18 AM, Administrative Nurse C stated the consultant pharmacist had not addressed the lack of bowel monitoring for this resident. The facility's consultant pharmacist failed to identify and address with the facility and primary physician, the staff's failure to follow the physician's orders for pulse monitoring and bowel monitoring in order to provide timely interventions, for Resident #31.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		

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F 431	Continued From page 30 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility had a census of 32 residents.The sample included 13 residents. Based on observation, record review and interview the facility failed to have an adequate system for the storage and destruction of unused medications and adequate reconcilliation for narcotics for 1 of 1 medication rooms. Findings included: - On 1/13/15 at 9:30 AM, observation of the facility's medication room revealed an unlocked 2 door wooden cabinet on the wall which contained an estimated 20 unit dose medication bubble packs and 55 pill bottles. Further observation of the medication bubble packs revealed numerous areas where medications had been removed from the cards in a random sequence. Further observation revealed a sharps container (a secured plastic container with a flip lid) containing approximately 3 inches deep of different shapes, sizes and colors of medications which when tipped forward, readily released medications out of the flip top lid.	F 431		

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F 431	Continued From page 31 Further observation of the unlocked cabinet revealed 2 bottles of Morphine Sulfate liquid (a narcotic pain reliever). One empty bottle prescribed for Resident #4. The other bottle contained 1(ml) millileter prescribed for Resident # 5. In the back of the cabinet, under bottles of medications, were 2 resident's wadded up controlled substance records for the morphine liquids. One record for Resident # 4 stating 1ml left in the bottle and 1 record for Resident #5 stating 2ml left in the bottle. On 1/13/15 at 10:00 AM, Administrative Nurse C verified the contents of the unlocked cabinet. Administrative Nurse C also verified the morphine sulfate liquid was a controlled substance and should have been locked up then destroyed. Administrative Nurse C stated the other medications in the cabinet belonged to residents who have been discharged, expired or had a medication dose change as far back as June 2014, and these medicatons should have been destroyed and not kept in the cabinet. On 1/13/15 at 10:10 AM, Registered Pharmacist H verified the medications which were in the cabinet. Registered Pharmacist H also verified the morphine sulfate liquid was not destroyed or diposed of properly and should have been in a locked cabinet. The 7/2012 facility policy for Controlled Medications, ordered, and Administration of Medications stated the director of nursing and the consultant pharmacist are to maintain the facility's compliance with federal laws and regulations in the handling of controlled medications. Controlled medications remaining in the facility after the order has been discontinued are retained in the facility in a securely locked area with only the	F 431		

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F 431	Continued From page 32 director of nursing having access until destroyed by consultant pharmacist. If the director of nursing is not available to lock up discontinued controlled substances the medications are to stay in the medication cart in double lock up until they can be locked up by the director of nursing. Current controlled medication accountability records and audit records are to be kept in a separate notebook. The facility failed to store and dispose of medications appropriately.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 33 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 32 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for the 32 residents who lived in the facility. The facility failed to ensure contact isolation procedures, appropriate care of urinary catheter drainage bags, blood glucose equipment and oxygen equipment. Findings included: - Cognitive impaired, independently mobile Resident #10's roommate, Resident #9, had a physician's order for contact isolation for a diagnosis of (MRSA) Methicillin-resistant Staphylococcus aureus (a resistant infection) and received dressing changes to draining skin wounds four times a week. On 1/14/15 at 9:45 AM, observation revealed Nurse Aide J assisted Resident #9 to transfer from his/her bed to a recliner chair in his/her room. Further observation revealed the full body lift sling which was attached to the lift sling	F 441		

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removed and thrown at the top of the resident's closet. Further observation of the resident revealed open and draining areas on his/her outer left thigh and the right side of his/her waistand blood on his/her gown. Nurse Aide J then moved the room divider curtain with unclean gloves on. Observation revealed staff removed their gowns and gloves, after resident care, then placed them in a clear plastic bag and carried the bag down the hallway out of the resident's room with no gloves on his/her hands. Nurse Aide J verified the facility did not have a trash disposal for biohazards. Further observation revealed the Resident #10 wandering around the room to use the same bathroom as Resident #9.

On 1/13/15 at 11:50 AM, observation revealed staff propelled Resident #24 in his/her wheelchair to the dining room, his/her urinary catheter bag attached under the wheelchair with bag dragging across the floor.

On 1/14/15 at 8:30 AM, observation revealed staff pushed Resident #1 in his/her wheelchair to the dining room, with an audible sound of the urinary catheter bag dragging across the tile floor.

On 1/13/15 at 11:20 AM,observation revealed Medication Aide G using a glucometer (instrument used to calculate blood glucose) for Resident # 29. Further observation revealed after completing the blood glucose testMedication Aide G wiped the glucomete off with an alcohol pad. Medication Aide G stated he/she usually uses a BDI super sanicloth germicidal disposable wipe to clean the meter between residents but the wipes were not available with the glucometer. Medication Aide G stated the facility has 2 glucometers and 7 residents in the facility have routine blood glucose testing.

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F 441	Continued From page 35 On 1/13/15 at 9:00 AM, observation revealed Resident #7, #10, #18, #21 and #26 had oxygen tubing placed on floors, bedside tables or on top of concentrators and not properly stored. On 1/13/15 at 4:10 PM, Administrative Nurse C verified the facility staff were to use biohazardous red bags for Resident # 9's trash and dispose of any dressing in biohazard bags. Administrative Nurse C also verified the facility does not have a biohazard trash receptacle available in the facility and staff are to wear gloves when transporting biohazard trash. On 1/14/15 at 11:40 AM, Administrative Nurse C verified the facility was not following the manufactures recommendations for cleaning the blood glucose meter which stated to disinfect the machine with Clorox Germicidal wipes between resident use. On 1/15/14 at 8:50 AM, Administrative Nurse C verified the staff should clean the urinary catheter port with an alcohol wipe, before reclamping the port, and not allow the urinary catheter bag to touch the floor. On 1/15/14 at 10:30 AM, Administrative Nurse C verified Resident # 7, 10, 18, 21 and 26's oxygen tubing was not correctly stored. On 1/15/14 at 11:10 AM, Infection Control Nurse D verified the facility had not been following the contact isolation policy for Resident #9. The facility did not have a biohazard trash receptacle and the resident was not to have a roommate due to the draining wounds. Infection control Nurse D also verified the facility had thought of moving Resident #9 to a different room due to the	F 441		

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F 441	Continued From page 36 resident needing contact isolation but had not yet done it. The 5/2014 facility policy for Contact Precautions, stated to place the patient in a private room. The staff should place resident trash in a red bag in a biohazard receptacle. Trash is to be carried with gloves on and disposed of properly. The 4/6/14 facility policy for Urinary Catheter Care directed the staff to not allow the catheter bag to touch the floor. The facility's Accucheck Inform II Blood Glucose System manufactures recommendations stated to use a Clorox Germicidal wipe to clean and disinfect the meter between resident use. The 6/3/2014 facility policy for Oxygen mask and Nasal Cannula stated when masks and nasal cannulas are not in use they are to be stored in a plastic bag with the resident's name and date on it and the equipment changed weekly. The facility failed to provide a safe, sanitary and comfortable environment to prevent the development and spread of infection for the 32 residents who resided in the facility.	F 441		